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PRETORIA for HHALE, PDISKIN, SMCNIVEN

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SUBJECT: STATUS OF FOOD/NUTRITION IN ZIMBABWE

SUMMARY

¶1. Following alarming news reports of severe malnutrition, vitamin deficiency disease and deaths among children and adults in Zimbabwe, country and regional USAID/Food for Peace staff visited primary health care facilities in four Zimbabwean provinces to verify reports. Findings were not adequate to definitively refute or support claims of pending disaster, but they suggest that, in general, despite clearly worsening food insecurity, the nutritional situation at present is not significantly different from the same time last year. New vulnerable groups are emerging from the ranks of salaried workers who can no longer rely on this resource to sustain them and their families. UNICEF and NGO partners as well as USAID and WFP are actively monitoring and responding to the nutritional situation in Zimbabwe. A nutritional surveillance exercise led by UNICEF is underway, and results are expected by the end of November. Country and regional Food for Peace staff have increased monitoring and joined the United Nations Nutrition Cluster Emergency Working Group. UNICEF has put its programs on emergency footing and has requested additional staff to bolster support for management of cases of severe malnutrition, providing training and therapeutic foods. NGO partners are expanding their roles in delivery of services. At present, Post is not recommending changes to current response until more concrete information is available that better defines unmet urgent needs. END SUMMARY.

Background

¶2. During the period Oct 28-November 2 Country and Regional Food for Peace (FFP) staff visited 15 primary health care facilities: two government hospitals, seven mission hospitals, and six rural clinics. At least one facility was visited in each of the four provinces of Matabeleland South, Matabeleland North, Midlands, Masvingo and Manicaland. (NOTE: This method of sampling does not allow assessment of the status of individuals who did not seek health care. There are many reports of people who have lost confidence in the health system and just stay at home. END NOTE.) Sites were chosen for accessibility and proximity to areas of news reports of malnutrition and were concentrated in areas of high cereal production deficit. Thus, they do not represent the situation in Zimbabwe as a whole.

¶3. FFP undertook the visits in response to news reports of severe malnutrition, vitamin deficiency disease (pellagra), and deaths among children and adults in Zimbabwe. The visits sought information that would indicate whether the prevalence of malnutrition has risen strikingly since the last round of nutritional surveillance (July 2008) and, if so, to get impressions about the underlying cause(s).

¶4. At all locations, most people interviewed expressed concern about food shortages; they are very concerned about low/no cereal production and poor food availability, and described heavy reliance on wild foods (e.g., fruits, roots, and other foods traditionally

eaten during times of scarcity.)

¶5. At a Manicaland hospital, a Sister in charge noted that the situation was "not much different from last year." She said that people were "used to" having no harvest and coped by getting food from neighboring districts or from food aid agencies. Information from the NGO Medecins Sans Frontieres (MSF), which works in the area (Buhera district), somewhat confirmed her statement. The local health staff and MSF jointly measured weight and height of under-5s in August on Child Health Data, and results indicated a prevalence of global acute malnutrition (wasting) of only 5.1 percent (greater than 10 percent suggests the possibility of generalized food shortage.) Still fearing the worst, all rural clinics in the district were equipped for outpatient therapeutic feeding. Admissions rose at first, presumably because of the increased proximity of service, but in recent weeks enrollment had dropped again.

¶6. Few health personnel were forthcoming with statistics. They had been advised by government officials not to share information. Most were willing to share some qualitative observations; a few showed us growth monitoring charts or monthly report forms; and some information could be gleaned from posters displayed on the walls.

¶7. However, the statistics routinely collected at the health centers are not sufficient to interpret the nutritional situation definitively. The growth monitoring data records "weight for age" (underweight) information for under-5s who come for immunization - a biased sample representing only children whose parents are concerned enough to bring them for vaccinations. Underweight is not as good a measure of acute distress due to food shortage or illness as is the prevalence of wasting ("weight for height," measuring thinness.) Notable is that since underweight includes wasted children, the prevalence of underweight will always exceed the prevalence of wasting.

¶8. Monthly reports include the number of cases of marasmus, kwashiorkor, and pellagra, by age category, but the number of people who were seen is not recorded, and thus, there is no way to calculate prevalence that would be useful to compare one period to another.

¶9. A house-to-house survey of children and adults, with measurement of both weight and height plus indicators of micronutrient deficiency, like the nutritional surveillance exercise currently underway (see below) is needed for a more valid interpretation of the population's nutritional status.

¶10. A comparison between growth monitoring data that was accessed from Manicaland clinics in September 2007 and September 2008 showed no significant difference. In the clinic with highest rates of underweight children, the percentages ranged from 3-9 percent in 2007 and 3-12 percent in 2008, with the peak of 12 percent in February 2008. In both August and September of 2008, the percentage was 6 percent. In the other clinics visited in the same district (Makoni), the range of percentages was lower (2.4-6.8 percent.)

¶11. Nevertheless, in most hospitals, staff felt that the number of admissions of severely malnourished children was higher this year than last. A doctor in one hospital in Midlands Province said there was a multi-fold increase in the number of cases admitted for outpatient treatment (OTP) compared to last year, but these figures are likely to be confounded by the fact that the national OTP program has only been fully developed and resourced over the course of the past few months. Generally, more cases present when they know treatment is offered.

¶12. At all locations, health personnel attributed much of the severe wasting and kwashiorkor among children to AIDS (40-70 percent, depending on location), based on confirmed tests. At hospitals in Midlands and Matabeleland North Provinces (Lupane, Nkayi and Kwekwe Districts) they noted that 60-70 percent of the malnourished children were sick with AIDS, TB or diarrhea.

¶13. Some health workers noted a potential link between diarrhea an malnutrition, but most believed that malnutritin preceded diarrhea, not vice versa. Only in Maabeleland North did staff report that they noticd a recent increase in cases of diarrhea - anecdotaly

linked to consumption of un-washed wild foodsand short water supplies. Generally, acute respratory infection was the most common illness amog those seeking treatment.

Adult Malnutrition

¶14. In Masvingo and Manicaland Provinces staff reporte some wasting among adults, but only among those beginning anti-retroviral treatment, which induces nausea and anorexia, and those with symptomatic AIDS.

¶15. Adults also presented with cases of pellagra, a form of malnutrition caused by niacin deficiency, in most of the locations visited (notably in only one of the six sites visited in Manicaland). At most of these locations, health personnel said that most individuals affected were elderly. They saw no association with HIV status. We noted that cases of pellagra also appeared on 2007 monthly reports that were viewed, indicating this phenomenon is not necessarily new.

¶16. Pellagra is associated with a poor quality diet, and is most common in areas of poverty where maize is the staple food (most other cereals provide sufficient micronutrients, particularly niacin, to avoid pellagra.) In Zimbabwe, the emergence of pellagra suggests over-dependence on maize (curious in a situation where maize is scarce) and the exclusion of other niacin-rich foods such as ground nuts, meat, milk, eggs and sweet potatoes. The higher occurrence among the elderly may be due to impaired absorption of nutrients due to age.

Hospital Salaries

¶17. Three facilities reported that retaining staff was difficult (50 percent staff levels) and those that did remain were difficult to control. A nurse's monthly salary was reported at between Z$50,000 and Z$100,000 (one loaf of bread cost Z$60,000 at the time). Transport costs to the banks ranged from Z$150,000 to Z$200,000. Twenty kilograms of maize meal was as much as Z$300,000. Many staff went to town to collect salaries, but had not returned due to the costs and low salaries. Staff that remained at the facilities often dropped all work as soon as rumors were heard that there was food available locally. Several of the nurses interviewed were visibly lethargic and tired. All nurses/aids were at a loss as to how to provide for their families. Every single person interviewed requested that either WFP's or C-SAFE's targeting criteria be reevaluated as they did not qualify for food aid as job holders. (COMMENT: While having a job is not exclusionary as a rule, people with jobs are often excluded by their communities during the targeting and registration process. As reported above however, having a job no longer means having the ability to cope with the current situation. END COMMENT.) Staff said their salaries bought literally nothing or they simply left the salary in the banks to "rot" as they couldn't afford transport. They said that they could no longer maintain themselves. Staff noted that they are dealing with sick people all day and now at greater risk of infection since they are physically weak and hungry. "Who is going to take care of the sick when things get worse as the hungry season progresses" was a comment made by a forward thinking nurse.

¶18. At the other facilities, while some staff complained about their salaries and the difficulties extracting it from the banks, they all looked fit and were energetic. Like other Zimbabweans, they are managing somehow by means that we don't understand.

Expanding Vulnerability

¶19. At the end of each interview we asked if they had access to seeds and fertilizers for their own home fields. All responded that they have not seen any on the market and communities were concerned about these shortages with the rains quickly approaching. Given the shortage of agricultural inputs and the early onset of this hungry season, it is probable that Zimbabwe now faces a prolonged period of

need - 18 versus the normal nine month period.

¶20. The Mission and its partners have, despite delays caused by the NGO ban, begun to distribute in the most affected areas of the country. The problem is that areas that were once of a lower priority are now increasingly vulnerable largely because there are few alternative sources of food and no money. Urban conditions are desperate as these people have relied on commercial markets and have few prospects to produce their own food.

Analysis of results

¶21. The data collected are not sufficient to support or refute recent reports of exceptional elevations in malnutrition due to massive food shortages. Generally, the findings imply that, despite feelings of heightened food insecurity, even in the areas of great cereal deficit, the nutritional situation does not differ dramatically from the same time last year. The data from the three hospitals in Matabeleland North and Midlands Provinces are most suggestive of deteriorating nutritional status, though the underlying cause (i.e., food shortage vs. illness or caring practices) is not clear.

¶22. However, the approach to data collection taken, i.e., canvassing a small sample of health service facilities that yielded largely qualitative information, cannot support conclusions that can be broadly generalized. Pockets of acute distress and individuals who do not seek care could easily be missed.

¶23. There are numerous international relief agencies that specialize in health and nutrition (e.g., MSF, ACF, Helen Keller International) currently operating in various parts of Zimbabwe. Most of their programs focus on supporting the failing health system in the context of HIV/AIDS, which necessarily includes treatment of severe malnutrition. These agencies are best positioned to recognize signs of pending disaster, and would normally alert the donor and emergency relief communities if increased incidence of malnutrition were observed. Significantly, none of these agencies has alerted USAID or UNICEF (the typical first responder in the coordination of such emergencies) of significantly rising incidence of malnutrition. This does not mean that malnutrition is not present in communities, but in the absence of comprehensive surveillance mechanisms, the relative silence of these expert "watchdog" organizations suggests that widespread malnutrition is not a concern at this time.

Zimbabwe Reasonably Prepared
To Treat Severe Malnutrition

¶24. At the beginning of the food security emergency in southern Africa, UNICEF supported capacity building in the 60-70 hospitals that treat severe malnutrition in therapeutic feeding units. At the insistence of the Ministry of Health (MOH), hospital staff members were trained only to follow a therapeutic feeding protocol using milk enriched with locally-produced commodities (oil, sugar). However, economic conditions over the course of the past eight months led to a collapse in the implementation of this protocol. Milk, oil and sugar are no longer readily available.

¶25. Responding to this collapse, a few months ago, UNICEF convinced the MOH to accept the use of imported therapeutic foods, specifically F-75 for stabilization followed by plumpy nut (F-100) until patients recover. UNICEF flew in an initial stock of F-75. Plumpy nut was already a familiar product used in a UNICEF-supported program of community-based treatment of severe malnutrition. Additional stocks of plumpy nut have been supplied by the Clinton Foundation. The therapeutic foods currently in or on their way to Zimbabwe are sufficient to rehabilitate 10,000 severely malnourished individuals.

¶26. UNICEF, in cooperation with the MOH, is training staff in the new protocol using F-75 and plumpy nut. This training must be accomplished before the products are delivered. Training has been completed in four rural provinces: Mashonaland West and East,

Matabeleland South and Manicaland, plus the cities of Harare, Bulawayo and Chitungwiza, and is partially accomplished in other provinces. Training has been temporarily on hold while nutritionists were involved in the UNICEF-led nutritional surveillance exercise. Notable was that 60 percent of facilities visited in Masvingo, Matabeleland North and Midlands - provinces where training hasn't been completed - were following the new protocol and had therapeutic foods in stock.

¶27. UNICEF fully stocked the units at hospitals with trained staff with both F-75 and plumpy nut. As supplies have been used up, some hospitals have experienced difficulties with re-stocking because, due to the breakdown in telephone coverage and prohibitive costs of travel, they are unable to communicate their needs to suppliers.

¶28. The primary constraint to progress in the roll-out of the new protocol has been that only about half of the MOH staff have been turning up for training. Apparently, the cost of bus fares has deterred others.

On-going Plans for Assessment and Response

¶29. With support from UNICEF and partner NGOs, the MOH is currently conducting a new round of nutritional surveillance. (The last was in July.) All data collection teams were expected to return from the field by November 19 to begin data analysis. In this round, the sites were selected to be representative at the Provincial level. (The previous represented only seven districts presumed to be among the worst cases.) This means that the results should uncover a change in a general trend within a province, but it will not pick up localized "hot spots." Any hint of a rising trend will be investigated further with focused nutritional surveys that will be more useful in identifying causes and defining the magnitude and nature of appropriate response. We should have preliminary results from UNICEF by the end of November, giving donors and emergency relief organizations much better insight on the situation and guidance on potential changes to response methods, if needed.

¶30. Nutrition partners have increased the coverage of outpatient treatment of malnutrition, especially in areas where, due to poor food availability, they expect malnutrition to rise. Next week World Vision will conduct an anthropometric survey in Matabeleland North (Bubi, Lupane and Nkayi Districts) to assess the need there. They recently opened nutrition activities in Gwanda District in Matabeleland South.

USAID/FFP Actions and Recommendations

¶31. No major changes to current response are recommended at this time until more concrete evidence emerges that the needs are different from planning estimates and pipeline requests. While post is concerned about the potential fluidity of the situation, it also understands the competing demands for food in the continent's other dire food emergencies.

¶32. It should be noted that Food for Peace and partners closely monitored the development of the last agricultural season and, when the harvest failed were already prepared to respond. From FY08 and FY09 funds, the USG has contributed more than US$211 million to support food assistance in Zimbabwe during the present hunger season, including 178,500 MT of food commodities. This represents about 76 percent of the international food aid for Zimbabwe for this season - an unusually large proportion compared to most other emergency contexts. Post requests that AID/W undertake a demarche to encourage other donor and non-traditional donors to increase their commitments.

¶33. The Harare-based FFP Officer, a nutritionist, has joined a newly-formed small group of specialists commissioned by the United Nations Nutrition Cluster to work on an emergency preparedness and response plan for the sector. The group met for the first time on November 18. Agenda items included: plans for assessment and surveys to follow on the November nutrition surveillance, links between nutrition and food aid programs, contingency planning for

rapid rises in reports of malnutrition, strengthening the treatment capacities and protocols for severe malnutrition and infant feeding in emergencies.

¶34. Post is taking several steps to increase monitoring of nutritional status. FFP's Food Security Specialists, who regularly monitor food aid activities and food security conditions, will now include interviews at rural health centers about nutritional status in their field visitation plans. The regional FFP Advisor will continue to make frequent monitoring trips to Zimbabwe to assist the in-country team in its efforts to increase scrutiny of the conditions and programs. FFP will continue to monitor the situation closely and maintain a high level of participation in the contingency planning exercise. To prevent malnutrition due to water-borne illness, OFDA continues to make water, sanitation and hygiene as a primary focus of their funding in Zimbabwe.

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